STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145602	A. Building B. Wing	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village at Victory Lakes, The	1055 East Grand Avenue Lindenhurst, IL 60046

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 40085 Based on observation, interview and record review the facility failed to ensure a resident bed had side rails for bed mobility for 1 of 18 residents (R34) reviewed for accommodation of need in the sample of 18. The findings include: On 2/5/24 at 10:35 AM, R34 said he was recently transferred from one room to this room and they gave him a new bed that doesn't have side rails on it. R34 said uses the side rails to help turn himself from side to side, and to shift positions. R34's bed had an air mattress with no side rails on it. On 2/6/24 at 11:18 AM, V16 (CNA) said she is not sure why R34 does not have the same bed but he did use the side rails to assist himself for re-positioning and turning. On 2/6/24 at 1:50 PM, V2 (Director of Nursing) said she was not aware that R34 was moved into a new bed without side rails but he should have side rails and does use them for bed mobility. On 2/6/24 at 11:21 AM, and 2/7/24 at 8:40 AM, R34's bed still did not have side rails on either side. R34's Face sheet shows he has diagnoses including: osteoarthritis, chronic obstructive pulmonary disease, morbid obesity and carpal tunnel syndrome. A Bed Rail/Assist Bar Evaluation completed on 1/22/24 for R34 shows he requested to have side rails for bed mobility. R34's active order summary shows an order for bed rail to assist with bed mobility initiated on 1/23/24.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 40085 Based on interview and record review the facility failed to provide a written notice of a room change, with rationale, to a resident prior to the resident's room change for 2 of 2 residents (R34 and R7) reviewed for resident rights the sample of 18. The findings include: 1. On 2/5/24 at 10:25 AM, R34 said he is so upset because he got moved again the other day without a warning due to his roommate being sick. R34 said he doesn't understand why he had to be the one to move from one room to the other and he wants to go back to his original room immediately. R34 said he refused to go at first but ended up giving in and let them move him. R34 said they did not give him any written notice and not much of a notice at all. A room change notification for R34's room change was requested from the facility. They provided a paper titled room transfer dated 2/2/24 showing R34 is moving from one room to another and a copy should be placed in his chart but did not identify a copy was given to the resident. 35541 2. On 2/5/24 at 9:15 AM, R7 was seated in a wheelchair in her room. R7's roommate was in bed, watching television (TV). R7 stated, I am not good. My new roommate has her TV on all night long. I can't sleep. I used to be in a different room. A couple of nights ago, they came in and told me I had to move to another room because something was going on with my old roommate. I didn't get a choice or even a heads-up. R7 stated she got nothing in writing telling her why she had to move into another room or if her new room change was permanent. A facility Room Transfer form dated 2/2/24 showed R7 was transferred to another room in the facility due to the isolation needs of R7's roommate. On 2/6/24 at 8:44 AM, V11 Director of Admissions stated the facility does not give residents any type of written notice in regards to a room change. V11 stated, (R7) has not been given anything in writing in regards to her room change. We try to give residents options of different rooms if they have to change rooms if that is available. I am not sure if (R7) was given any options prior to her move on 2/2/24. She was moved during the evening. I wasn't here when she was moved I am not sure if anyone has followed up with her to see how the room change is going . The facility's Change of Room or Roommate policy dated 5/1/19 showed, The resident has the right to be informed in advance and in writing, to include the reason for the change, before the room or roommate in the community is changed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on observation, interview and record review the facility failed to ensure pressure relieving interventions and pressure injury treatments were in place. The facility failed to report a new pressure wound. These failures apply to 4 of 8 residents (R40, R34, R62, R432) reviewed for pressure injuries in the sample of 18. The findings include: 1. R40's care plan dated 11/29/23 showed R40 was at risk for pressure injuries and/or skin breakdown due to his diagnoses of limited mobility, incontinence, and cognitive deficits. R40's skin/wound note dated 2/3/24 showed R40 was readmitted to the facility, from the hospital, with a new wound to his sacrum that measured 1.5 centimeters (cm) x 0.3 cm x 0.1 cm. The note showed R40 was referred to the facility's wound physician. R40's Order Summary Report dated 2/3/24 showed a physician order for R40's sacral wound to be cleansed with normal saline and covered with an absorbent, foam dressing, every 12 hours as needed for soiled or missing dressing. On 2/5/24 at 9:31 AM, R4 was lying in bed, with his call light on. An odor of stool was noted in R4's room. V12 Infection Prevention Nurse entered R4's room. R4 stated, I think I need a bed pan. V12 rolled R4 onto his side to place a bed pan under him, but R4 was already incontinent of a moderate amount of loose stool. A small, open area was noted to R4's sacral area. No dressing was covering R4's wound and no soiled dressing was noted in R4's incontinence brief. Stool was noted on and around R4's sacral wound. On 2/6/24 at 10:22 AM, V6 Wound Nurse stated R40 was readmitted to the facility on [DATE] with a new wound to his sacrum. R40 stated, Wounds to the sacral area are usually pressure injuries. There are orders for (R40) to have a dressing place over his wound. It should be covered at all times until he sees the wound physician this week. The facility's Pressure Ulcer Prevention and Treatment policy dated 3/3/23 showed. The facility must have a system in place to ensure that care staff and licensed nurses are appropriately initiating intervention, treatment, evaluation and documentation to attempt to prevent further deterioration and provide appropriate interventions for healing. 40085 2. On 2/5/24 at 10:25 AM, R34 said he has a new sore on his heel that has been there since last week. R34 said he wears heel protectors but his heel was hurting so he mentioned it and the (unidentified) staff person looked at it and said he has a sore there so she put a bandage on it. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/24 at 10:35 AM, V6 (Wound Care Nurse) said no one had reported to her that R34 had a new sore on his heel so she had not assessed the area before today. V6 said R34 has an unstagable pressure area to his right heel measuring 1.5 x 0.4 x 0 depth. V6 said she is unable to say for certain how long he has had the new pressure injury but whomever discovered it should have let her or the other wound nurse know so they could have seen him to assess the wound. V6 said the nurse who discovered it should obtain treatment orders also if the wound nurses are not present. On 2/6/24 at 11:18 AM, V16 (CNA) said she noticed a bandage on R34's heel on Saturday 2/3/24 and he told her he had a sore on his heel. V16 said R34 is usually wearing boot style heel protectors and he takes them off only for bed baths and when he gets up on weekends for bingo. On 2/7/24 at 8:36 AM, V26 (Wound Nurse) said he was not aware until yesterday when the facility called him to ask if he knew about R34's new pressure injury. V26 said no one had informed him of the injury and they could not determine who discovered it because the bandage was not dated or initialed. On 2/7/24 at 8:40 AM, V25 (Wound Care Physician) was providing wound care and doing an assessment of R34's right heel. V25 measured R34's right heel (which presented as a patch of dried skin) to be 0.3 x 0.4 x 0.1 centimeters after V25 removed some slough tissue. The area to R34's heel was superficial and V25 described it as a stage 2 due to the area that sloughed off. V25 said if staff identify a new skin condition for a resident they need to tell the wound care nurse immediately so orders can be obtained. V25 said ideally staff should be checking under R34's pressure prevention boots daily but generally those boots will not cause pressure if the foot is properly positioned in them. R34's Braden Scale to determine pressure risk completed 12/22/23 shows he is at risk to develop a pressure injury. A Skin Observation tool completed for R34 on 2/4/24 (After V16 had seen a bandage on R34's heel) shows No new skin issues. A Skin and Wound Evaluation assessment was not completed for R34 new pressure injury until 2/6/24. R34's active Order Summary shows no treatment orders were obtained for his pressure injury until 2/6/24. The facility provided Pressure Ulcer Prevention and Treatment policy revised on 3/3/23 shows residents should have daily inspection of the skin and any alterations should be reported to the nurse. The licensed nurse will notify the attending physician of any skin alteration. And any pressure ulcers the wound nurse will complete the Skin & Wound Evaluation weekly. 3. On 2/5/24 at 9:25 AM, R62 was lying in bed, his heels were not offloaded and no pillow was underneath his feet. [NAME] boot style heel protectors were sitting in a reclining chair across the room from his bed. On 2/6/23 at 8:48 AM, R62 was in bed, his heels were not offloaded, and his heel protectors were sitting in the same spot in his reclining wheelchair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R62's care plan shows he has a self care deficit and requires maximum staff assistance to turn and reposition. R62's care plan also shows he has a stage 4 pressure injury to his sacrum and left heel. R62's active order summary shows he is to have pressure off loading boots on every shift. R62's Braden Scale for Pressure risk completed 2/3/24 shows he is at a moderate risk to develop new pressure injuries. R62's Wound Evaluation completed 1/31/24 by V25 (Wound Care Physician) shows he has a stage 4 pressure injury to his left heel. A plan of care intervention shows that R62 should have pressure off-loading boots on when in bed. On 2/6/24 at 10:40 AM, V6 (Wound Care Nurse) said for pressure prevention the nursing staff are responsible to make sure R62 has his heel protectors on. The facility provided Pressure Ulcer Prevention and Treatment policy revised on 3/3/23 shows residents at risk for skin impairments should have orders implemented including repositioning and pressure relieving devises. 34490 4. On 2/5/24 at 1:45 PM, V4 and V5 (Certified Nurses Assistants) transferred R432 to bed. R432's heels were placed directly onto the bed. R432's heel protection boots were sitting on his dresser. V4 and V5 exited the room without placing the heel protector boots on R432. R432 stated, Honey, can you put those boots on, they are supposed to be on. R432 said that he currently has some wounds on his foot that are new. On 2/6/24 at 12:35 PM, V6 (Wound Licensed Practical Nurse) performed a dressing change on R432. R432 had a blackened pressure wound on his left heel and a wound on his left posterior ankle. On 2/6/24 at 10:41 AM, V6 said that R432 admitted to the facility with a deep tissue injury of his medial heel and then developed an unstageable pressure ulcer on his left heel on 2/4/24 that was facility acquired. V6 said that R432 should have his heels offloaded by wearing heel protection boots while he is in bed. R432's Physician's Order Sheet printed on 2/6/24 shows an order dated 1/26/24 for heel protector boots while in bed every shift for wound prevention. R432's Skin/Wound Notes dated 2/4/24 shows, During L (left) ankle TX (treatment) this AM an intact, serum filled blister was observed to the resident's R (right) medial heel (3.5 x 3) Orders were received to continue skin prep and heel protector boots until seen by [Wound Physician]. The facility's Pressure Ulcer Prevention and Treatment policy revised on 3/3/23 shows, Reposition resident per care plan using pressure relieving devices (i.e. low air loss mattress, pillows, etc) to prevent bony prominence from rubbing as applicable.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on observation, interview and record review the facility failed to provide restorative services to residents with limited mobility for 3 of 5 residents (R34, R4, R26) reviewed for restorative services in the sample of 18. The findings include: 1. R34's current care plan showed R34 had diagnoses including osteoarthritis, right foot drop, carpal tunnel syndrome of the upper limb, spinal stenosis, and a history of falls. R34's current care plan showed no focus area, goals, or active interventions related to restorative programming. R34's most recent PT (Physical Therapy) Therapist Progress and Discharge Summary dated 1/19/22 showed discharge recommendations for R34 as include in (R34's) daily schedule to be up in wheelchair and maintenance therapy for ROM (range of motion exercises) to BLE (bilateral lower extremities). R34's medical record showed R34's last PT session was 1/18/22. R34's most recent OT (Occupational Therapy) Therapist Progress and Discharge Summary dated 8/23/22 showed R34 received OT related to his diagnoses of severe right foot drop, contracture to his left arm, and generalized weakness. The summary showed R34's OT discharge instructions as recommendations discussed with patient and/or caregivers include Restorative Program. R34's medical record showed R34's last OT session was 8/19/22. On 2/7/24 at 8:40 AM, R34 was in bed with his left hand contracted into a fist. Foot drop was noted to his right foot. R34 had no splint or brace to his left hand or right foot. When R34 was asked to relax the fingers to his left hand, R34 stated, I can't open my fist. I have really bad carpal tunnel to my left hand. I don't have a splint for that hand. When R34 was asked about receiving restorative cares including ROM exercises, R34 stated, I haven't had any exercise since the last time I had therapy. I would like someone to work with me to get stronger. I can't even help roll myself right now in bed. On 2/7/24 at 8:54 AM, R34's medical record, dated February 2023-February 2024, was reviewed with V2 Director of Nursing (DON). No restorative assessments or contracture assessments were noted for R34. V2 stated, I see that (R34's) previous PT and OT discharge recommendations were for him to receive restorative services but he didn't get any. We don't have a restorative program. We don't have a restorative nurse. We don't do restorative assessments or contracture assessments. We are trying to get a program up and running. If therapy recommends ROM exercises for a resident upon discharge from therapy, we try to carry over their recommendations but we can't guarantee is gets done. On 2/7/24 at 8:45 AM, V22 Director of Rehabilitation Services stated the facility did not have a restorative program. V22 stated, I have been told we are working on getting one. When a resident is discharged from therapy and it's appropriate, we make recommendations for restorative programming which could include ROM exercises, walking programs, and/or splints but, I can't guarantee what we recommend will get done. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R4's resident assessment dated [DATE] showed R4 had limited mobility to her upper and lower body on one side. R4's current care plan showed R4 had a diagnosis of cerebral infarction (CVA) with paralysis to her right arm and right leg. The plan showed R4 was cognitively impaired and dependent on staff for cares including transfers and toileting. The care plan showed no focus area, goals, or interventions related to restorative programming for R4. R4's most recent PT Therapist Progress and Discharge Summary dated 3/3/23 showed R4 was discharged from PT with instructions of patient discharged to long term care with recommendations including nursing maintenance program for ROM (exercises) for bilateral upper and lower extremities. R4's last PT session was 3/3/23. R4's OT Therapist Progress and Discharge Summaries were reviewed and showed R4 last received OT on 10/24/19. On 2/6/24 at 9:31 AM, V2 DON stated no restorative assessments or contracture assessments were completed on R4 from February 2023-February 2024. V2 stated R4 received no restorative services from February 2023-February 2024. 3. R26's resident assessment dated [DATE] showed R26 had limited mobility to his bilateral lower extremities. R26's current care plan showed R26 had diagnoses of CVA with paralysis to his right arm and right leg, diabetic neuropathy, and amputation to both legs, below the knee. The care plan showed no focus area, goals, or interventions related to restorative programming for R26. R26's most recent PT Therapist Progress and Discharge Summary dated 3/28/22 showed R26 was discharged from PT with instructions of patient was discharged to long term care with recommendations including maintenance program from nursing for ROM (exercises), positioning and schedule of patient to be up in the wheelchair during meals. R26's last PT session was 3/28/22. R26's OT Therapist Progress and Discharge Summaries were reviewed and showed R26 last received OT on 10/31/17. On 2/6/24 at 9:31 AM, V2 DON stated no restorative assessments or contracture assessments were completed on R26 from February 2023-February 2024. V2 stated R26 received no restorative services from February 2023-February 2024. The facility's Restorative Nursing policy with an effective date of 9/1/23 showed, It is the policy of (facility) to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practical level . The Interdisciplinary Team, with the guidance from the resident's physician, will assure the ongoing review, evaluation, and decision making regarding the services needed to maintain or improve resident's abilities in accordance with the resident's assessment, goals, and preferences .Residents, as identified during the assessment process, will receive restorative services. These services may include: passive or active range of motion, splint or brace assistance, bed mobility training, training and practice in transfers or walking .

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview and record review the facility failed to ensure residents were transferred in a safe manner. This failure resulted in R432 being sent to the hospital for 8 days due to increased pain after a transfer. The facility also failed to ensure a resident with a diagnosis of dyspagia was supervised during meals and failed to ensure a resident was provided nectar thick liquids as ordered. This applies to 4 of 18 residents (R5, R7, R44 and R432) reviewed for safety in the sample of 18. The findings include: 1. R432's Face Sheet shows that he originally admitted to the facility on [DATE]. R432's Physical Therapy Evaluation dated 1/8/24 shows that he was referred to therapy for strengthening and decrease level of assistance in bed mobility and transfer. The report shows, Patient exhibiting difficulty performing bed mobility, transfer, sitting balance and ability to stand. The assessment shows that he needs maximum assistance of 2 people for transfer and is dependent on staff for bed-to-chair transfers and has no reports of pain. The assessment shows that R432 is alert and oriented to person, place and time. On 2/5/24 at 1:50 PM, R432 said that he had to go to the hospital due to severe back pain after an incident with a transfer. R432 said that he was using the slide board to transfer from his wheelchair to his bed. R432 said that once he got to the side of the bed, the aide that was behind him came to the front of him and he fell back in bed because no one was supporting his upper half and he hurt his back. R432 said that the pain was a 12 out of 10. R432 said that it was horrible. R432 said that before the incident he would have back pain when he moved but it was only at a 6 out of 10. R432 stated, I had to go to the hospital after that. I could not even lay in the MRI machine, it hurt so bad. They had to sedate me. R432's History and Physical dated 1/8/24 shows, admitted with spinal stenosis with lumbar myelopathy . lumbar fusion and spinal cord stimulator. He is feeling better. R432's Rehabilitation Practitioner Note dated 1/9/24 shows that his pain is 4-5 out of 10 Bed mobility maximal assistance x 2. Slide board transfers-maximal to total assist of 2 . R432's Nursing Note dated 1/10/24 at 5:36 PM shows, Resident complained of severe pain 10/10 stated that he had never felt this bad before and was very concerned. Given norco as ordered with relief. Called [Physician] and made aware. New order received for stat x-ray of the lumbar spine and lidocaine patch . R432's Nursing Notes dated 1/13/24 at 10:00 PM shows, patient complained of pain while sitting in his wheelchair. He is scheduled for PT Norco 5/325 1 tab given at 3:26 PM. He refused to go to therapy due to pain. Patient was put back to bed with 2 assist using the sliding board pain is getting worse per patient 10/10 and unbearable want to go to hospital requesting to call 911 picked up the patient at 4:48 PM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R432's Hospital Notes dated 1/13/24 shows, Presents to ED (Emergency Department) chief c/o (complaint of) low back pain; today while in PT (Physical Therapy), fell backwards onto mattress .Patient requiring multiple doses of narcotics to manage his pain; doesn't feel safe returning to rehab. Plan for admission for pain control, symptom stabilization. R432's Hospital Notes dated 1/14/24 shows, Patient reports he had been doing fair at SNF (Skilled Nursing Facility), but still with significant weakness. Patient reports he had a fall/injury to his back earlier this week while working with PT, for which he was started on a medrol dose pack (steroids) on 1/11. Then today patient was again working with PT and fell backwards on to the bed and had acute worsening of his left sided low back pain of which he presents today .pain control-oxycodone (narcotic pain medication), flexeril (muscle relaxer), lidocaine and diclofenac patches, hydromorphone (narcotic pain medication) for breakthrough . On 2/6/24 at 11:18 AM, V7 (Nurse Supervisor) said that R432 was a slide board transfer and was complaining of increased pain after a transfer. R432 was sent to the hospital for a few days and came back with an increase in pain medication and is now a mechanical lift transfer. On 2/6/24 at 1:18 PM, V21 (Nurse Practitioner) said that R432 was readmitted to the hospital for severe back pain but she was unaware of any incidents that happened that caused the pain. On 2/7/24 at 8:58 AM, V23 (Occupational Therapist) said that when R432 was first admitted , he was able to use the slide board for transfers with two people. V23 said that when R432 first came in, he was unable to sit on the side of the bed independently. V23 said that for a two person assist slide board transfer, the patient should be assisted from the wheelchair to the bed by placing the slide board between the bed and the chair. V23 said that once the resident is in bed, one person should assisted with his trunk due to poor trunk control and one person should assist with his legs and move him to a laying positron in one swift movement so there would be no strain on the back especially with his history of back problems. V23 said that R432 needs assistance with trunk support at all times unless he would fall over in bed. On 2/7/24 at 9:24 AM, V24 (Certified Nursing Assistant) said that himself and another aide put R432 to bed on the evening of 1/10/24. V24 said that they used the slide board. V24 said that after a resident is assisted to the side of the bed with the slide board, one person would direct the resident's feet and one person would direct their trunk. V24 said that he did not remember if he was assisting with the feet or trunk. V24 said that he did not remember if R432 fell back in bed or not and V24 said that he did not remember if R432 complained of pain after the transfer. R432's Face Sheet shows that he was readmitted to the facility on [DATE]. R432's Physical Therapy Evaluation dated 1/22/24 shows he requires maximum assistance of two persons for bed mobility and totally dependent on staff for transfers and is in severe pain. R432's Medication Administration Record (MAR) for January shows that between 1/7/24 and 1/10/24 he was taking a lidocaine patch to his lower back daily and norco 5/325 milligrams (mg)-1 tablet every 4 hours as needed for pain. R432 took the norco five times for pain of 4 to 7 out of 10. After 1/10/24, R432 took norco 5/325 mg-1.5 tablets every 4 hours as needed for pain 12 times between 1/10/24 and 1/13/24 for pain of 3 to 10 out of 10. R432's MAR shows that when readmitted from the hospital on 1/21/24 he was ordered oxycodone 5 mg every 4 hours as needed for pain and flexeril 5 mg every 8 hours as needed for muscle spasms. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	35541 2. R5's care plan dated 11/20/23 showed R4 was at risk for choking or aspiration due to her diagnoses of dysphagia and dementia. The care plan showed R5 had a history of pneumonitis due to aspirating food and/or fluids. The care plan showed R5 will be assisted by CNAs (certified nursing assistant) if she eats in her room .Needs supervision during meals, cut foods into small pieces and redirect the resident to chew and swallow one at a time, slowly . R5's hospital records showed R5 was hospitalized on [DATE] with a diagnosis of gastrointestinal bleeding. R5's hospital speech therapy evaluation dated 12/8/23 showed R5 required a mechanical soft with nectar thick liquids due to her risk of choking. The evaluation showed R5 must be fed by staff to ensure R5 was eating slowly and was following the recommended feeding cues. The evaluation showed R5 was not to have straws in her drinks due to her choking risk. R5 was discharged from the hospital, back to the facility, on 12/14/23. On 2/5/24 at 11:56 AM, R5 was in bed, eating lunch. No staff were present in R5's room. R5 swiftly scooped food into her mouth; occasionally dropping food onto her lap. No coughing was noted from R5. Two Styrofoam cups with lids and straws, one containing thickened coffee and the other thickened water, were noted on the tray, directly in front of R5. On 2/5/24 at 1:03 PM, R5 remained in bed. One Styrofoam cup, with a lid and straw, was noted in front of R5 on her bedside table. The contents of the cup appeared to be non-thickened water. V8 Licensed Practical Nurse (LPN) entered R5's room. She picked up the cup, opened the lid and shook the cup, and stated, That's regular water. That's not thickened. V8 closed the cup and placed it back down in front of R5. V8 exited the room. On 2/6/24 at 9:39 AM, V9 Speech Therapist (ST) stated R5 has dysphagia that is chronic and ongoing. V9 stated R5's last speech therapy session was 12/5/23. V9 had not evaluated R5 since she had been readmitted from the hospital on 12/14/23. V9 stated, I saw her in December because staff had reported she was coughing during meals. Upon evaluation, I downgraded her diet to mechanical soft and regular liquids. Upon her discharge from me, I said she needed direct, 1:1, supervision when eating due to her dysphagia and tendency to eat to fast. It looks like her fluids were changed to nectar thick in the hospital . I also see the (physician) order for no straws. She has a tendency to drink and eat too fast. Straws have a tendency to make people gulp and drink faster. That's why she probably shouldn't be using straws. 3. R7's care plan dated 12/4/23 showed R7 required the use of a sit-to-stand (mechanical) lift, with the assistance of two staff, for all transfers and toileting due to her unsteady balance and generalized weakness. On 2/5/24 at 11:41 AM, V10 CNA transferred R7, via sit-to-stand lift, from a wheelchair to the toilet. R7 was hanging onto the lift with her hands. R7's knees were bent as she was unable to bear weight and stand. No other staff were noted in R7's room. On 2/6/24 at 9:31 AM, V2 Director of Nursing (DON) stated all resident transfers, via a sit-to-stand, are to be performed by two staff members, not one. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's Lifting Machine, Using a Mechanical policy dated July 2017 showed, At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. 4. R44's care plan dated 12/20/23 showed R44 required the substantial assistance of one staff when being transferred from bed to wheelchair. On 2/5/24 at 10:35 AM, V16 CNA transferred R44, from her bed to a wheelchair, by lifting R44 up, under her armpits, and pivoting her into the chair. R44 was unable to bear weight during the transfer or hold onto V16. No gait belt was used during the transfer. On 2/6/24 at 9:31 AM, V2 DON stated gait belts are to be used to transfer any resident that requires staff assistance. The facility's Gait Belt policy dated 6/1/23 showed, Gait belts are to be used for all transfers that require staff assistance and when assisting residents to ambulate.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on interview and record review the facility failed to report a resident's decreased oral intake and failed to identify a resident's severe weight loss. These failures apply to 1 of 5 residents (R4) reviewed for weight loss in the sample of 18. The findings include: R4's care plan dated 12/30/23 showed R4 was at risk for impaired nutrition. The care plan showed, Monitor weight as ordered. Monitor oral intake of food and fluid . The care plan showed no significant weight loss for R4. R4's Comprehensive Nutritional assessment dated [DATE] showed R4 was evaluated by V13 Registered Dietician (RD), based on R4's weight of 159 pounds (lbs) from 1/3/24. The assessment showed no significant weight loss for R4. R4 was not on any dietary supplements. The assessment showed, RD to monitor po (oral) intake/weight/labs/meds/skin integrity. RD available prn (as needed) . R4's Weight Summary Records showed R4 weighed 159 lbs on 1/3/24 and 125 lbs on 2/2/24. R4 was weighed in a wheelchair on 1/4/24 and via mechanical lift on 2/2/24. Once R4's weight loss was identified on 2/5/24, R4 was reweighed in a wheelchair, as she was previously on 1/3/24, with a corrected weight of 140 lbs. This showed a significant weight loss of 12% (19 lbs) in one month, from 1/3/24-2/5/24. On 2/5/24 at 1:12 PM, V14 Certified Nursing Assistant (CNA) stated, I weighed (R4) last week (2/2/24). I didn't notice her weight loss. Come to think of it though, her appetite has really gone down lately since she's had RSV (Respiratory Syncytial Virus). V14 stated she did not report R4's decreased appetite to nursing or V13 RD. On 2/5/24 at 12:45 PM, V13 RD stated she did not become aware of R4's weight loss until she ran a computerized facility weight loss report on 2/5/24. V13 stated, No one notified me of (R4's) weight loss. I found it today when I ran the report. If a significant weight change is found, the resident should first be reweighed. If a weight change is confirmed, staff should notify nursing, the physician, dietician, and family right away. Had I been notified, I would have started her on supplements that day. There is no documentation showing that staff identified her weight loss on 2/2/24, when she was weighed. If staff notice a weight change, they usually make a progress note showing the change and who was notified. Any nurse can start a resident on supplements for weight loss once they get an order from a physician. I am seeing her today. I will start her on supplements today. V13 stated no staff had reported R4's decreased appetite to her. On 2/5/24 at 1:06 PM, V8 Licensed Practical Nurse (LPN) stated, I did not find out about (R4's) weight loss until today. The CNAs weigh the residents. The CNAs should be looking at the previous weights to monitor for weight changes. Any discrepancies should be reported immediately so we can notify the dietician and physician. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/24 at 9:19 AM, V2 Director of Nursing (DON) stated the facility was not aware of R4's weight loss until it was brought to the attention of the facility by this surveyor. V2 stated, We weren't aware of her weight loss until you brought it to our attention yesterday. CNAs weigh the residents. They report these weights to the resident care managers (RCM). The RCM then documents the weight in the computer. The RCM is responsible for looking back at previous weights to check for any big changes. The RCM can then request for the resident to be reweighed. All our RCM's are nurses so they should notify the dietician and physician of any significant weight changes immediately. The RCM didn't catch (R4's) weight loss. V2 stated a decrease in a resident's appetite should be reported to nursing as soon as possible. On 2/6/24 at 10:12 AM, V15 Nurse Practitioner stated R4 is seen by her physician once a month, but I would see her if she had any changes, or if they needed to get orders for anything. V15 stated, I was not aware of (R4's) weight loss. It is significant. Weight loss should be identified as soon as possible so we can get interventions started and assess the resident. Any nurse can call us to get supplements started right away. We should notified if a resident isn't eating. The facility's Weight Management in Health Care Centers policy dated 9/1/22 showed, Purpose: To provide a systematic and interdisciplinary approach to obtaining and monitoring of resident weights . The staff nurse will validate that the weight is within acceptable limits. If a resident has a gain or loss of 5 pounds from their previous weight, a new weight will be obtained within 48 hours . The Registered Dietician is responsible for monitoring all weight changes and documenting significant weight loss/gain. Significant weight loss/gain is defined as greater/less than 5% in one month, greater/less than 7.5% in 3 months, or greater/less than 10% in six months .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40085 Based on observation, interview and record review the facility failed to ensure residents were free from medication errors. There were 29 opportunities with 2 errors resulting in a 6.9% medication error rate. This applies to 2 of 10 residents (R26 and R434) reviewed for medication administration in the sample of 18. The findings include: On 2/5/24 at 11:46 AM during medication pass, V3 (Registered Nurse) prepared a Novolog Insulin Pen to administer R434 her insulin. V3 put the needle onto the pen and dialed the pen to 9 units and administered the insulin. V3 did not prime the pen before administering the insulin. On 2/5/24 at 12:27 PM, V3 stated, Insulin pens should be primed with one unit before giving, I think. On 2/6/24 at 11:27 AM, V7 (Registered Nurse) said that insulin pens should be primed with 2 units before administering the insulin to ensure that the resident receives the ordered dose of insulin. V7 said that the staff should put the needle on, turn the dial to 2 units and push the button and then turn the dial to the required dose and then administer it. The facility's Insulin Pen Policy dated 12/1/23 shows, Attach pen needle .Prime the insulin pen. Dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle Turn the dose selector to ordered dose On 2/6/24 at 8:51 AM, V19 and V20 both (Licensed Practical Nurses/LPNs) were observed together passing morning medication. V20 said she was in training so she is orienting with V19. At 9:05 AM, during the med pass V20 went into R26's room to measure his blood sugar with a reading of 361. At 9:10 AM, V20 administered 3 scheduled units of Novolog insulin and based on sliding scale perimeters drew up 10 additional units and administered it to R26. V19 said ideally blood glucose checks and insulin should be done prior to meal times. V20 said there are so many residents who need to need their blood sugars checked that they were not able to get to them all before the residents ate breakfast but resident blood glucose levels should be taken prior to eating so the readings are accurate. R26's active order summary report show an order for Insulin Aspart Solution 3 units subcutaneously in the morning before breakfast. The same order summary shows sliding scale orders for additional insulin based on blood sugar levels with a level of 350-399 to give 10 additional units of Novolog insulin. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided Medication Administration Policy with an effective date of 6/1/2023, shows that Medications should be administered according to physician orders.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review the facility failed to ensure it was free of significant medications errors for three of three residents (R182, R434, R26) reviewed for significant medication errors in the sample of 18. The findings include: 1. R182's Order Summary Report dated February 5, 2024 shows she was readmitted to the facility on [DATE] with diagnoses including urinary tract infection, history of falling, acute duodenal ulcer with hemorrhage, helicobacter pylori, and cognitive communication deficit. R182's Progress Note dated January 14, 2024 at 9:02 PM shows, Resident became unresponsive while using the toilet around 8:15 PM. Writer was called by CNA (Certified Nursing Assistant) to check on the resident. Her vital signs were within normal limits and still breathing. Primary Care Provider and Family were notified that she will be sent to the hospital due to the incident. Resident was picked up by ambulance around 8:30 PM. R182's Hospital Paperwork dated January 19, 2024 shows, Your medications have changed: start taking bismuth subsalicylate (pepto-bismol), metronidazole (flagyl), pantoprazole (protonix), sucralfate (carafate), and tetracycline (sumycin). R182's Practitioner Progress Note dated January 20, 2024 at 8:21 AM shows, Return to the hospital on January 14 for a syncopal episode and dark tarry stool. She diagnoses with anemia, duodenal ulcer, and H pylori. She received a blood transfusion and had an EGD (esophagogastroduodenoscopy) on January 16, 2024 which found many non bleeding gastric ulcers and one duodenal ulcer which was the source of her bleeding. The ulcer was injected with epinephrine and she was started on antibiotics, protonix, pepto bismol, and sucralfate for her ulcer. R182's Medication Administration Record (MAR) dated January 1, 2024-January 31, 2024 shows an order dated January 20, 2024 for pepto-bismol oral tablet chewable 262 mg give two tablets by mouth four times a day for hyperacidity for 14 days (January 20, 2024-February 2, 2024). R182's MAR shows she did not receive eighteen doses of pepto bismol for the month of January. R182's MAR dated February 1, 2024-February 29, 2024 shows R182 did not receive any doses of pepto bismol for the month of February. R182's MAR for January and February 2024 shows she did not receive 26 out of 56 doses of prescribed pepto bismol. R182's Medication Progress Notes shows R182's pepto bismol was not available on January 21, 2024, January 22, 2024, January 27, 2024, January 28, 2024, January 29, 2024, January 30, 2024, January 31, 2024, February 1, 2024, and February 2, 2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 6, 2024 at 1:07 PM, V21 Nurse Practitioner said R182 was transferred to the local hospital on January 14, 2024 due to a change in condition. V21 said R182 was diagnosed with anemia, stomach ulcer, and h pylori positive. V21 said h pylori is a bacteria that causes stomach ulcers. V21 said the prescribed treatment for R182 was antibiotics, protonix, carafate, and pepto bismol. V21 said that pepto bismol is used in treatment because it helps heal the stomach lining, reduce the acid in the stomach, and to help with symptoms. V21 said if treatment is not administered as order, then the ulcer wouldn't get treated and heal. Omitting treatment could cause the ulcer to continue to bleed, and the resident will continue to be anemic. On February 6, 2024 at 1:31 PM, V2 DON (Director of Nursing) said that pepto bismol is a stock medication. V2 said she know pepto bismol liquid is a stock medication, but was not sure if the chewable medication was an in house stock medication. V2 said if the facility does not have a medication, then staff can order the medications through the pharmacy. V2 said she expects for staff to call the doctor and see if they can change the chewable tablet to a liquid. The facility's Medication Administration Policy dated June 1, 2023 shows, Medication are administered in accordance with written orders of the prescriber. 34490 2. R434's Face Sheet shows diagnoses of: diabetes mellitus. R434's Medication Administration Record shows an order for Novolog FlexPen-Inject 5 units subcutaneously with meals and an order for Novolog FlexPen as per sliding scale: 200-249=4 units. On 2/5/24 at 11:46 AM, V3 (Registered Nurse) performed a blood sugar check on R434 and her blood sugar was 214. V3 prepared a Novolog Insulin Pen to administer R434 her ordered insulin. V3 put the needle onto the pen and dialed the pen to 9 units and administered the insulin. V3 did not prime the pen before administering the insulin. On 2/5/24 at 12:27 PM, V3 stated, Insulin pens should be primed with one unit before giving, I think. On 2/6/24 at 11:27 AM, V7 (Registered Nurse) said that insulin pens should be primed with 2 units before administered the insulin to ensure that the resident receives the ordered dose of insulin. V7 said that the staff should put the needle on, turn the dial to 2 units and push the button and then turn the dial to the required dose and then administer it. The facility's Insulin Pen Policy dated 12/1/23 shows, Attach pen needle .Prime the insulin pen. Dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle Turn the dose selector to ordered dose 40085 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 2/6/24 at 8:51 AM, V19 and V20 both (Licensed Practical Nurses/LPNs) were observed together passing morning medication. V20 said she was in training so she is orienting with V19. At 9:05 AM during the med pass V20 went into R26's room and did an accu check to measure his blood sugar the reading was 361. V20 said there are so many residents who need to need their blood sugars checked that they were not able to get to them all before the residents ate breakfast but resident accu checks should be taken prior to eating so the readings are accurate. V20 said because R26 had eaten his breakfast his blood sugar is high and he will now also need additional sliding scale insulin coverage. V20 administered 3 scheduled units of Novolog insulin and based on sliding scale perimeters drew up 10 additional units and administered it to R26. V19 said ideally accu checks and insulin should be done prior to meal times. R26's active order summary report show an order for Insulin Aspart Solution 3 units subcutaneously in the morning before breakfast. The same order summary shows sliding scale orders for additional insulin based on blood sugar levels with a level of 350-399 to give 10 additional units of Novolog insulin. On 2/6/24 at 1:50 PM, V2 (DON) said accu checks and insulin should be administered prior to breakfast, and the accu check reading wont be accurate for the sliding scale coverage amount if a resident has already eaten his meal. The facility provided Medication Administration Policy with an effective date of 6/1/2023, shows that Medications should be administered according to physician orders.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 33760 Based on observation interview and record review the facility failed to serve residents the right amount of food to 4 of 4 residents on pureed diets (R38, R433, R62, R12) reviewed for nutritional needs of residents on pureed diets in the sample of 18. The findings include: The facility Diet type report dated 2/5/24 show R38, R433, R62 and R12 were all on pureed diets. The facility spreadsheet for 2/5/24 show the serving size for pureed diet was as follows, steamed broccoli- 4 ounces (oz), cheesy grits-4 oz and grilled chicken broccoli tortellini-6 oz. On 2/5/24 at 12:30 PM, during the lunch service V17 (Dietary Aide) was plating the lunch trays with pureed consistency foods. V17 used a blue scoop for the pureed steamed broccoli and cheesy grits. V17 said those blue scoops were 2 ounces (oz.) Then V17 used the green scoop to serve the pureed chicken tortellini and said the green scoop was 3.5 oz. On 2/6/24 at 11:30 AM, the facility spreadsheet for 2/5/24 was reviewed with V13 (Dietitan) and V18 (Dietary Manager). Both V13 and V18 confirmed that V17 did not use the right scoop sizes according to the spreadsheet V13 (Dietitian) said residents should receive the right amount of food to maintain their weight and receive the nutritional requirements. On 2/6/24 at 1:00 PM, V18 (Dietary Manager) said he had given inservices for staff to follow the spreadsheet and pay attention to the scoop they were using when serving food to the residents. The facility policy under Dining Services dated 10/25/22 shows the community's dietary department should utilize the appropriate service utensils when portioning food items during service.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145602	A. Building B. Wing	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village at Victory Lakes, The	1055 East Grand Avenue Lindenhurst, IL 60046

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on interview and record review the facility failed to provide specialized rehabilitation services, including speech therapy (ST), physical therapy (PT), and occupational therapy (OT), to a resident for 1 of 13 residents (R5) reviewed for skilled therapy services in the sample of 18. The findings include: R5's hospital records showed R5 was hospitalized on [DATE] with a diagnosis of gastrointestinal bleeding. R5 was discharged from the hospital, back to the facility, on 12/14/23. R5's physician orders summary report, dated 12/14/23, showed orders for R5 to be evaluated and treated by ST, PT, and OT, upon readmission to the facility. R5's ST-Therapist Progress and Discharge Summary Report showed R5 was last seen by speech therapy on 12/5/23. On 2/6/24 at 1:30 PM, V9 Speech Therapist stated, The last time I treated (R5) was before she was hospitalized in December. I haven't seen her since she got readmitted . On 2/6/24 at 1:50 PM, R5's electronic medical record was reviewed with V22 Director of Rehab Services. V22 stated, I see the orders, on 12/14/23, for her to get PT, OT, and speech. She didn't get any of these services. I wasn't notified of these orders when she got readmitted . The last time she had occupational or physical therapy was last spring (2023). When residents get readmitted , I usually get an email from admissions that notifies me of what therapy each resident needs. They email me a copy of the orders along with what insurance each resident has. I will then go ahead and schedule the resident for the therapy that is ordered. I never got an email on (R5) so I wasn't aware of these orders. The facility's Scheduling Therapy Services policy dated July 2013 showed, Therapy services shall be scheduled in accordance with the resident's resident's treatment plan. The therapist shall interview the resident and consult with the attending physician as to the type of treatment to be administered. Therapy is scheduled in coordination with nursing service and is documented in the resident's medical records .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34490 Based on observation, interview and record review the facility failed to ensure glucometer machines were cleaned in between resident use and failed to ensure Personal Protective Equipment (PPE) was worn appropriately for a resident on contact/droplet isolation for COVID-19 to prevent the spread of infection. This applies to 5 of 18 residents (R16, R434, R182, R8, R432,) reviewed for infection control in the sample of 18. The findings include: 1. On 2/5/24 at 11:35 AM, V3 (Registered Nurse) performed a blood glucose check on R16. After performing the check, V3 took a disinfecting wipe and set it on the nurse's cart. V3 placed the glucometer machine in the center of the wipe and folded the wipe over the top of the machine. V3 had another machine on the cart and wrapped it in the same manner. V3 then checked R434, R182 and R8's blood sugars and wrapped the machines in the same manner after each use. On 2/5/24 at 11:27 AM, V7 (Nurse Supervisor) said that glucometers should be cleaned after each use by vigorously wiping the front, back and sides of the machine using a disinfectant wipe for two minutes and then allowed to air dry before using again. V7 said that it needs to be done that way to prevent infections. The facility's Glucometer Use and Cleaning Policy dated 1/1/24 shows, Retrieve (2) disinfectant wipes from container. Using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer. After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, wipe all surfaces, top, bottom, and sides. Follow the contact time. 2. On 2/5/24 at 9:00 AM, V2 (Director of Nursing) said that R432 is on isolation due to being positive for COVID-19. On 2/5/24 at 1:45 PM, there was a sign on R432's door that showed he was on contact/droplet isolation. V4, Certified Nursing Assistant (CNA) applied a N95 mask, gloves and a gown and entered R432's room. V5 (CNA) applied a N95 mask over her surgical mask, gloves, gown and faceshield and entered R432's room. V4 and V5 performed a mechanical lift transfer to transfer R432 from his wheelchair to bed. During the care, V5's mask kept slipping off of her nose. On 2/6/24 at 11:27 AM, V7 (Nurse Supervisor) said that COVID isolation should include a N95 mask, gloves, gown and a faceshield and should be put on before entering the room. V7 said that staff should not wear a surgical mask under the N95 because it will change the seal of the mask and each staff member has been fitted for the appropriate fitting mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 policy dated 6/3/20 shows, PPE must be donned correctly before entering the patient area. PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted (e.g., retying gown, adjusting respirator/facemask) during patient care . Put on isolation gown, Put on NIOSH-approved N95 filtering facepiece respirator or higher .Put on face shield or goggles .